WINTER 2001

Alcohol, Tobacco, and Other Drugs

Prevention File

- Cities Take on Methamphetamine Problems
- Promoting Public Health or Public Problems?
- Blazing New Trails in Canada with Alcohol Policies

As Healthy as an Athlete?

It's commonly believed that teenagers who take part in sports are less likely than their nonathletic peers to smoke or drink. However, a new study contradicts that idea and says, in fact, athletes may engage in high-risk drinking and smoke cigarettes even more than their classmates.

"The same things that makes these athletes excel–a certain amount of risk-taking–may be the same things that increase their vulnerability to substance use," researcher Shashank V Joshi, MD, from Stanford University in California, said in a Reuters dispatch. Joshi presented the study of 1,769 California high school students at the 47th annual meeting of the American Academy of Child and Adolescent Psychiatry.

According to the study, some athletes exhibited increased cigarette use in comparison to nonathletes, but they were also more likely to have future plans to stop smoking. Athletes were also more likely to engage in high-risk drinking—a possible consequence of a culture that involves "getting wasted after the game," Joshi said. And increased exposure to advertisements for alcoholic drinks prominently displayed in sports arenas may lead to an increased risk of the behavior, he added.

Another Risk Posed by Underage Drinking

A national survey of 42,862 adults offers another sobering argument against underage drinking. People who start drinking while underage are up to three times more likely to get hurt in car crashes and other alcohol-related accidents than those who start at age 21 or older, according to the study, which was reported in the *Journal of the American Medical Association* (Sept.27, 2000).

Ralph Hingson, ScD, and other researchers at the Boston University School of Public Health, who conducted the study, said those who start drinking before age 14 are 12 times more likely to be injured than those who begin drinking at or after age 21. After adjusting for history of alcoholism, family history of alcoholism, and other characteristics associated with early-onset drinking, the researchers found that people who begin drinking before age 14 are about three times more likely than those who begin drinking at or after age 21 to be injured while drinking.

"Our report shows that younger age of drinking onset is associated with frequent heavy drinking later in life—not only for persons who are alcohol dependent but also for other drinkers. This is part—but not all—of the reason that early drinking heightens the injury risk for persons both above and below the legal drinking age," said Hingson.

"These findings provide important information for physicians and other health care providers to share with their adolescent patients."

Drug Use and Crimes Up in Russia

According to an Associated Press dispatch, government officials in Russia are alarmed by sharp increases in both drug use and drug-related crimes. In fact, drug use is spreading so rapidly that the Kremlin regards it as a threat to national security, the head of the Russian Security Council, Sergei Ivanov said at a recent national drugs conference held at Danilov Monastery, the seat of the Russian Orthodox Church.

Ivanov says that the rate of drug-related crimes has risen 14-fold over the past decade, with more than 200,000 such crimes registered in the past year. Some 4 million of 145 million Russians use drugs and about half are considered addicts, according to Public Health Minister Yuri Shevchenko.

"The president of Russia and the Security Council he chairs consider the problem of the spreading and using of drugs in the category of a direct threat to the national security of the state because of its long-term consequences," Ivanov said.

Much of the narcotics used in Russia is believed to come from the former Soviet Republics in Central Asia, especially Tajikistan, and Russia accuses insurgents in the region, believed to be trained in Afghanistan, of taking part in drug trafficking.

Talking Replaces Smoking for Teens?

According to a letter in the *British Medical Journal* (October 26,2001), the incredible rise in use of mobile phones may be a key factor in the decline in teenage smoking in Britain since 1996. That's because mobile phones successfully compete with cigarettes to meet certain important needs of teenagers.

Clive Bates, director of Action in Smoking and Health and co-author of the letter argues, "The trends for mobiles and for teenage smoking are very striking, but our main observation is just how closely mobiles overlap with cigarettes in what they do for teenagers. It's more than just something to do with the hands; mobiles are smart, chic, and adult. They allow individuality and self-image to be projected through choice of brand and model, and, like cigarettes, they are important in socializing. If their friends are using mobile phones to organize social life on the move, then for some kids a mobile is going to be seen as essential —effectively a peer group pressure.

"With the pay-as-you-go mobile phones young people are even spending their money in the same way and in the same places as they would purchase cigarettes. Some won't be able to afford to do both, and others might get all they want from owning a mobile, and for them smoking might become irrelevant."

Between 1996 and 1999 teenage, (age 15) smoking fell from 30 percent to 23 percent. By August 2000, mobile phone ownership among 15-to-17-year-olds had reached 70 percent. The fall in teenage smoking has already met government targets for 2010.

However, the authors emphasize that the relationship between mobile phone use and smoking is only a hypothesis at this stage.

"We don't yet know what has happened to teenage smoking in 2000, but if the decline in teenage smoking is linked to rising mobile phone ownership, then we might hope for a continuing reduction in smoking. How to persuade kids not to smoke has always been the Holy Grail of health promotion campaigners, and it's just possible that the mobile phone industry has inadvertently stumbled across something that works," say Bates and his co-author Anne Charlton, professor emeritus at the University of Manchester.

The Honeymoon Is Over

Heavy drinking by husbands during the beginning of a marriage may help predict whether a husband will become violent in subsequent years, but it is the differences between the drinking behavior husbands and wives that appear to matter the most, according to a report in *Alcoholism: Clinical and Experimental Research*, (No. 24, 2000).

Continued on inside back cover

Prevention File is a publication of The Silver Gate Group
(Federal Tax ID: 33-0714724)

Opinions expressed herein are those of the authors or other sources cited and do not necessarily reflect the beliefs of The Silver Gate Group, its editorial advisors, its officers, or its personnel.

Publisher: Tom Colthurst
Editor: Barbara E. Ryan
Editor Emeritus: Robert Zimmerman
Associate Editor: Angela Goldberg
Orange County Editor: Cindi McGaughan
Los Angeles County Editor: Yolanda Cordero
San Diego County Editors: Bill Crane, Ron Yardley
Ventura County Editors: Kathleen Staples
Contributing Editors: Rodney Skager, Margie Farnsworth, Anthony Ramirez, Sarah Reichel, Jean Seager
Design/Illustrations: John Lane
Production: J. Lane Designs
Printer: Precision Litho

Prepaid domestic subscription rate: $25/one year, $40/two years, $55/three years. Bulk order discount prices available upon request. Canada: $29 USD/one year, Beyond: $39 USD/one year. Address: Prevention File, 4635 West Talmadge Drive, San Diego, CA 92116-4834.
ISSN 1065-3961 (National edition)
ISSN 1065-3953 (Orange County edition)
ISSN 1530-3454 (Los Angeles County edition)
ISSN 1065-3593 (San Diego County edition)

Comments and suggestions are welcome.
Address letters to *Prevention File*,
4635 West Talmadge Drive, San Diego, CA 92116-4834.
Internet: prevfile@silvergategroup.com
http://silvergategroup.com

PREVENTION FILE

Contents

Winter 2001 • Volume 16, Number 1

COVER
"Meth"
by J. Lane Designs

AP Wide World Photo

CITIES TAKE ON METHAMPHETAMINE PROBLEMS

By Tom Colthurst

ONCE CONTENT TO BUILD PARKS, OPEN LIBRARIES, AND PROMOTE ECONOMIC DEVELOPMENT, U.S. mayors today also have to "know about drugs and alcohol and what they do the brain and what our cities need to do to cut down on suicides, unwanted pregnancies, and the need for police to endanger themselves by busting methamphetamine labs," says Brent Coles, mayor of Boise, Idaho, and president of the U.S. Conference of Mayors.

Coles told a national conference in Portland, Oregon, last fall that that police and hospital statistics on methamphetamine have gone up in Boise, from practically nothing when he became mayor in 1993, to hundreds of arrests for 2000. According to Coles, his city and state believe that prevention is imperative, along with law enforcement and the availability of effective treatment and recovery services, to reduce risks that have increased "dramatically."

"My city has a population of 170,000. My police officers are busting a meth lab every week and the emergency rooms of our two regional hospitals are overwhelmed on weekends by methamphetamine and other illicit drugs and alcohol-induced casualties. We have to do something," Coles said.

Preventive measures in Boise, as well as other U.S. cities, include an outreach program to owners and managers of rental property that combines education and code enforcement. Boise city officials train property managers on ways to screen prospective tenants and to monitor the environment for signs of illicit activities, such as manufacturing and storing

HAZARDOUS METH LABS

An estimated 20 to 30 percent of known methamphetamine laboratories were discovered because of fires and explosions, putting those first on the scene, such as firefighters, police officers, or emergency medical technicians, at risk for injuries, according to a report from the Centers for Disease Control and Prevention (*Mortality and Morbidity Weekly Review,* November 17, 2000).

The report says that health departments in 14 states reported 79 police officers, firefighters, and medical technicians were injured between 1996 and 1999.

"With these meth labs, essentially each one is like a mini-toxic-waste site," said Kevin Horton, a CDC epidemiologist. "These people manufacturing the labs, they're not the most educated in terms of what these chemicals can do. Before you know it, there's a fire or explosion."

Methhamphetamine is manufactured in illicit laboratories using over-the-counter ingredients that often are corrosive, explosive, flammable, and toxic, and can cause fires, explosions, and other uncontrolled reactions. Meth labs can be found in motel rooms, private residences, campgrounds, motor vehicles, and other environments.

Hazardous substances released during and after an event at a meth lab usually enter the body by inhalation and skin absorption. Acute exposures may result in cough, headache, chest pain, burns, pulmonary edema, respiratory failure, coma, and death. Of those most likely to show up first at such events, police officers had the greatest number of injuries because they were present during and immediately after a release. EMTs sustained most injuries through on-site exposure or direct contact with the clothing or skin of contaminated persons.

methamphetamine and its precursor chemicals and by-products. In addition, any Boise apartment complex warranting two police actions due to illicit drugs in a six-month period is subject to an aggressive response of health and safety inspections, which may prevent occupancy of vacant units that fail to meet relevant municipal codes.

Mayor Coles credited Chicago's Mayor Richard Daley for developing this bundle of landlord education and code enforcement.

Earlier last year, the Conference of Mayors and the National Center on Addiction and Substance Abuse at Columbia University released a report, based on federal information, that found "eighth-graders living in rural America (to be) 104 percent likelier to use amphetamines, including methamphetamine, than those in urban areas . . . ," according to an accompanying media release. The full report, *No Place to Hide: Substance Abuse in Mid-Size Cities and Rural America,* is on the World Wide Web at www.casacolumbia.org

Jane Taylor, PhD, illustrated the West to East geographical spread of methamphetamine use. It started in the early 1990s in California, then moved into the adjacent states of Nevada and Oregon, expanded into most of the mountain states, and then gained popularity in the Midwest. Taylor, who is with the Substance Abuse and Mental Health Services Administration, said that her data came from health facility admissions records of persons seeking treatment for drug use.

Richard Rawson, PhD, speaking at the same Oregon conference, described the adverse social consequences of methamphetamine use. The UCLA researcher pointed out that clandestine manufacturing labs have led to explosions, fires, and toxic wastes. According to Rawson, leakage of chemical residue from a meth lab had contaminated the public water supply in San Luis Obispo, CA, requiring a four-day quarantine.

Rawson also described the fetal toxicity of the drug, citing a recent study conducted in San Bernardino County, with support from the SAMHSA Center for Substance Abuse Treatment. According to Rawson, this small-scale study, which compared the birth outcomes of 50 methamphetamine-using mothers with 50 nonusing mothers, was one of the few such studies involving human subjects. The most significant finding was the impairment of verbal learning capability among meth-exposed infants. He likened that consequence to a similar finding of cognitive impairment within adult meth-users.

The conference, organized by the U.S. Department of Health and Human Services, through its Center for Substance Abuse Treatment, part of the SAMHSA, is an outgrowth

GETTING INFORMATION ABOUT METHAMPHETAMINE ONLINE

The following are some Internet sites that have information on methamphetamine prevention and treatment.

- The Methamphetamine Treatment Project is a multi-site initiative to study the treatment of methamphetamine dependence. Jointly implemented by the UCLA Drug Abuse Research Center and the Matrix Institute on Addictions, its goal is to generate knowledge regarding how a new comprehensive treatment protocol developed by Matrix can be effectively transferred to the community drug treatment system. The project which is funded by the Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment can be found at www.medsch.ucla.edu/som/npi/DARC/mtcc/mtcc.htm
- The National Clearinghouse on Alcohol and Other Drug Information has educational publications and fact sheets at www.health.org/pubs/qdocs/meth/index.htm
- The Drug Enforcement Administration provides a succinct summary of pharmacology, availability, and efforts to interrupt trafficking channels at www.usdoj.gov/dea/concern/meth.htm
- The California Department of Justice hosts a methamphetamine page through its Stop Drugs Website, including prevention tips for self-storage and mini-storage operators at www.stopdrugs.org/methcrisis.html

of a federal government interagency task force established in 1996. The task force released a report last year as a step toward a "comprehensive national action plan for limiting future methamphetamine use and dealing with the effects of current use."

The report also found that:

- Just four percent of the clandestine manufacturing facilities—dubbed 'superlabs'—were responsible for 80 percent of production and were able to produce 10 pounds of methamphetamine in a 24-hour period. Most of these labs are in California.

My police officers are busting a meth lab every week and the emergency rooms of our two regional hospitals are overwhelmed on weekends by methamphetamine and other illicit drug and alcohol-induced casualties.

- Preemptive activities by law enforcement can prevent a methamphetamine problem before it begins in communities not yet "in the grip" of widespread sales and use.
- Constant threat of arrests as described by Mayor Coles—can disrupt the trafficking patterns in locales with established markets.
- Early detection and warning systems to identify potential methamphetamine and other synthetic drug manufacturing and distribution, as well as intelligence-sharing across jurisdictions (not only law enforcement, but also health care providers and educators) are highly recommended.

Methamphetamine is an artificial stimulant producing intoxication, dependence, and psychosis, according to the task force report. Adverse consequences include brain damage, cognitive impairment and memory loss. The drug is associated with violence and—for those who inject—hepatitis and HIV transmission.

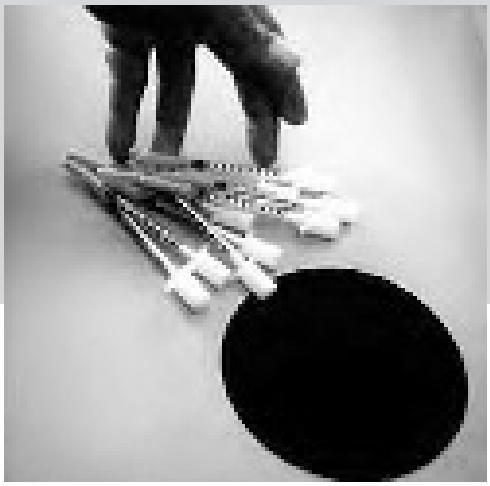
Methamphetamines have been around for over 100 years. Several antecedents have medicinal value as a decongestant and were popular during and after World War II for their stimulant properties. Recently, labs and distribution networks in Mexico have begun to supply the United States market, adding to availability, conference participants learned.

Four federal agencies made up the interagency task force. They are the White House Office of National Drug Control Policy and the departments of Justice, Health and Human Services, and Education. A copy of the final report is available on the Web at www.ojp.usdoj.gov/nij/methintf/1.html

---

Tom Colthurst is publisher of Prevention File *and also co-director of the SAMHSA/CSAT-supported Pacific Southwest Addiction Technology Transfer Center at the University of California, San Diego.*

Promoting Public Health or Public Problems?



It is estimated that more than 100 needle-exchange programs are operating in the United States today.

IN A RECENT CONTROVERSY IN THE CITY OF SAN DIEGO capsulizes the national debate that continues over the effectiveness and the ethics of providing clean-needle exchanges to intravenous drug users to prevent the spread of HIV and deadly hepatitis infections.

It is estimated that more than 100 needle-exchange programs are operating in the United States today, covering about 80 cities in 30 states. These programs are said to have exchanged 17 million needles or syringes a year.

Yet, more than 15 years after their introduction as a prevention tool to stem the rising incidence of AIDS and hepatitis, needle-exchange programs remain a flashpoint for both the scientific and political communities.

The San Diego example is typical. In mid-October, the City Council voted to declare a public health emergency regarding hepatitis C and to establish a task force to develop a one-year needle-exchange program. Hours of public testimony included comments from the city's police chief, who voiced his opposition and concern that the program would be a magnet for crime. Representatives from the County Board of Supervisors—the entity traditionally charged with public health emergency declarations—spoke in opposition, disputing that any health epidemic exists.

Researchers, on the other hand, cited County data that show the number of cases of hepatitis C doubled from 1998 to 1999. Council members also heard poignant accounts of local children suffering from hepatitis C that was contracted prenatally from drug-injecting mothers.

In the weeks leading up to the Council's vote, a spate of pro and con letters to the editor of *The San Diego Union-Tribune* recapped the basic points of differences:

- A leading cause of hepatitis C and HIV is injection drug use and sharing contaminated syringes; if a drug addict cannot be "cured," then it is incumbent on public health officials to minimize the harm the user does to himself and to his environment—a concept generally known as "harm reduction."
- Needle exchanges may increase illegal drug use, encourage non-injection users to become injectors, cause recovering drug addicts to relapse, increase crime in areas where needles are handed out, and send a message—particularly to impressionable young people—that these programs condone illegal drug use.

In an editorial the newspaper urged the Council to reject the needle-exchange measure, saying, "This unorthodox approach ignores the

Supporters of needle exchange often cite its potential as a so-called bridge to treatment, whereby the exchanges are linked to more traditional drug-education and drug-treatment programs.

hard reality that there simply is no way to make drug abuse safe." Sanctioning needle exchange, the editorial said, abets intravenous drug use and promotes "even larger social ills."

Given these polarized and emotional points of view, what dispassionate information exists about needle-exchange programs? An overview of that question is contained in a recent issue of *American Journal of Public Health* (September 2000), wherein leading public health researchers examine the issue.

"Apart from wars, few things are as political as an infectious disease pandemic," writes A.R. Moss, PhD, of the department of epidemiology and biostatistics at San Francisco General Hospital.

He notes there is "a general perception" that scientific studies show needle-exchange programs help to prevent HIV infection. He adds, however, that two recent Canadian studies and one U.S. study undermine this. The first Canadian study shows the needle-exchange program to have little effect on a growing HIV outbreak among drug injectors, and the second study indicates that the needle-exchange program might even have raised risks for HIV infection. The U.S. study, conducted in Seattle, indicates that a needle-exchange program had no protective effect against hepatitis B or C.

Moss says that while the research on which these studies were based is limited, they have nonetheless "put a dent in the idea that needle exchanges provide an easy solution to the problem of infectious disease transmission among drug users."

He says the debate has become polarized for two main reasons. First, with its introduction in the mid-1980s as awareness of the AIDS epidemic was growing, needle-exchange options were promoted very rapidly into the political process, often without any significant research to substantially back them up.

"There was almost no organized, prospective research work set up during the first years of the needle-exchange programs," Moss writes, "and this is probably the main reason the early political decision making was done in a data vacuum."

Secondly, Moss says the issue of needle exchange—like most modern health initiatives—became part of a "moral crusade," one that was "driven by gay activism and powered by the idea that stigmatization should not prevail."

Overall, Moss calls needle-exchange programs "an impressive intervention that must surely work," and urges researchers to continue to apply pressure for more thorough studies.

The concept of needle-exchange programs was introduced in the United States in 1986 in a presentation by Roel A. Coutinho, MD, PhD, with Municipal Health Services of Amsterdam, who also writes in the *American Journal of Public Health*.

Since that presentation, Coutinho says, "pragmatic supporters of needle exchange and their moralistic opponents seem to be immobilized in a trench war," delaying the availability of "good data."

Acknowledging the recent Canadian and U.S. studies, he writes, however, "there is also no evidence that needle-exchange programs do any harm in areas where the drug epidemic is well established. These programs do not increase the use of illegal drugs, nor is there evidence for increased transitions from non-injection to injection drug use."

Supporters of needle exchange often cite its potential as a so-called bridge to treatment, whereby the exchanges are linked to more traditional drug-education and drug-treatment programs. The advantage of this is cited by David Vladhov, PhD, of the Center for Urban Epidemiologic Studies of the New York Academy of Medicine.

He said U.S. studies have shown that "injection drug users attending needle-exchange programs avail themselves of links to treatment, and there are data showing that referrals from needle exchange are more likely than standard referrals to represent clients without prior treatment experience."

One of the earliest researchers of needle-exchange programs is Don C. Des Jarlais, PhD, of Beth Israel Medical Center, Chemical Dependency Institute in New York City. Des Jarlais says that the "first-generation questions" on research of needle-exchange programs have been answered. He writes:

"No increases in illicit drug use have occurred in association with needle-exchange programs, and there is no reason to expect such increases in the future," adding, "as part of a larger HIV prevention program, needle exchange usually, but not always, leads to low rates of HIV-transmission among injection drug users."

According to Des Jarlais it is now time to answer what he calls "second-generation questions" about needle exchange. He said these include:

- Why do some needle-exchange programs seem to be more effective than others in reducing HIV transmission?
- How should needle exchange be coordinated with such other HIV-prevention efforts as community outreach?
- What services in addition to an exchange should be provided?
- How can needle-exchange programs be used to reduce hepatitis B and C among injecting drug users?

He calls for continued research into the needle-exchange option but also echoes a theme expressed by other researchers:

"Value conflicts over needle exchange, which have existed since it was considered in the United States, cannot be resolved with data."

Book Review
Case Histories in Alcohol Policy

GRASSROOTS GROUPS ACROSS THE COUNTRY ARE TAKING ACTION to change their neighborhoods and communities when it comes to how alcoholic beverages are served, sold, and promoted. And some of these groups have enjoyed remarkable successes through advocating for alcohol policy reforms—and then seeing those reforms put into place.

But these stories are often overlooked in both the popular media and the research literature, so other communities cannot benefit from the experiences of those who have succeeded in reducing community problems. Now the stories of seven organizations that have worked to reduce alcohol-related problems—in particular, injury and violence—are documented in a new publication from the Trauma Foundation in San Francisco.

Called *Case Histories in Alcohol Policy*, this publication sets out to "bridge the gap between community action and research." The stories selected for telling met a set of criteria established by the Trauma Foundation and a project advisory panel. For example, the activities needed to have a "significant focus on alcohol-related injury and violence" and represent a range of environmental approaches to alcohol-related problems."

Case Histories documents the activities of the following groups.

- Preventing Alcohol-Related Trauma in Salinas mobilized a large group of volunteers to successfully protest plans to grant an alcohol license to a supermarket. Instead, they got the developer to lease the property to a day-care center.
- San Antonio's Fighting Back's Bi-Cultural Organization for Leadership Development targeted billboards promoting alcohol and tobacco to youths in the city's predominantly poor African-American and Latino East Side, and convinced local billboard companies to replace the alcohol and tobacco billboards with youth-designed billboards relaying positive messages.
- The Pomona Community Wellness Partnership is working with other groups in California to eliminate alcohol sales and sponsorship of *Cinco de Mayo* celebrations.
- Action on Alcohol and Teens is a Minneapolis-based program aimed at policy change to reduce underage drinking.
- Maryland Underage Drinking Prevention Coalition lobbied the state legislature to enact a keg registration law as one way to reduce youth access to alcohol.
- Gallup, New Mexico, focused on problems of public intoxication by mobilizing community-based organizations and city officials and raising taxes on alcohol, earmarking the revenue for prevention.
- The Vote Dry movement in Chicago used a 1907 law allowing voters to prohibit alcohol sales in a voting precinct to address alcohol-related problems.

In addition to telling stories that don't often get told, *Case Histories* tells them in an lively, engaging, and clear narrative style. That is because the Trauma Foundation sought out professional journalists and writers to get the stories and write them for a popular audience.

Case Histories in Alcohol Policy was supported by a grant from the Robert Wood Johnson Foundation. It is available online at www.tf.org/tf/alcohol/ariv/ or by calling the Trauma Foundation at 415/821-8209.

BLAZING NEW TRAILS in Canada with Alcohol Policies

By Reggie Caverson, Cindy Smythe, Ronald R. Douglas, and George Leakey

THE CANADIAN PROVINCE OF ONTARIO boasts close to 50,000 kilometers of groomed snowmobile riding trails and over 350,000 registered snowmobile riders. These winter trails are built and maintained primarily by volunteer members from an alliance of 281 snowmobile clubs called the Ontario Federation of Snowmobile Clubs. The OFSC sells about 125,000 trail use permits annually that allow public access to this network of trails that links communities across Ontario, as well as adjacent provinces and states. According to the OFSC, this sport contributes an estimated $1 billion annually to tourism in Ontario.

But as this sport has grown, so has the body of evidence that links snowmobile collisions with alcohol use—especially when the operator of the snowmachine is impaired. A study of snowmobile deaths in Ontario between 1985 and 1990 indicated that 59 percent of snowmobile operators had blood-alcohol levels exceeding the legal limit prior to the crash, and that 69 percent had been drinking. Studies conducted in the United States and Sweden have yielded similar findings.

. . . 59 percent of snowmobile operators had blood-alcohol levels exceeding the legal limit prior to the crash . . .

The Prevention Partnership and Emerging Tools

In 1996, the OFSC and the Centre for Addiction and Mental Health formed a partnership to minimize alcohol-related problems, including crashes. Additional partners included the Ontario Snowmobile Safety Committee, Ontario Association of Chiefs of Police, the Ontario Ministry of Transportation, and the Insurance Brokers Association of Ontario. According to an OFSC survey conducted in the previous year, 88 percent of clubs hosted events where alcohol was served. And survey respondents believed that alcohol was often used illegally on club-maintained riding trails.

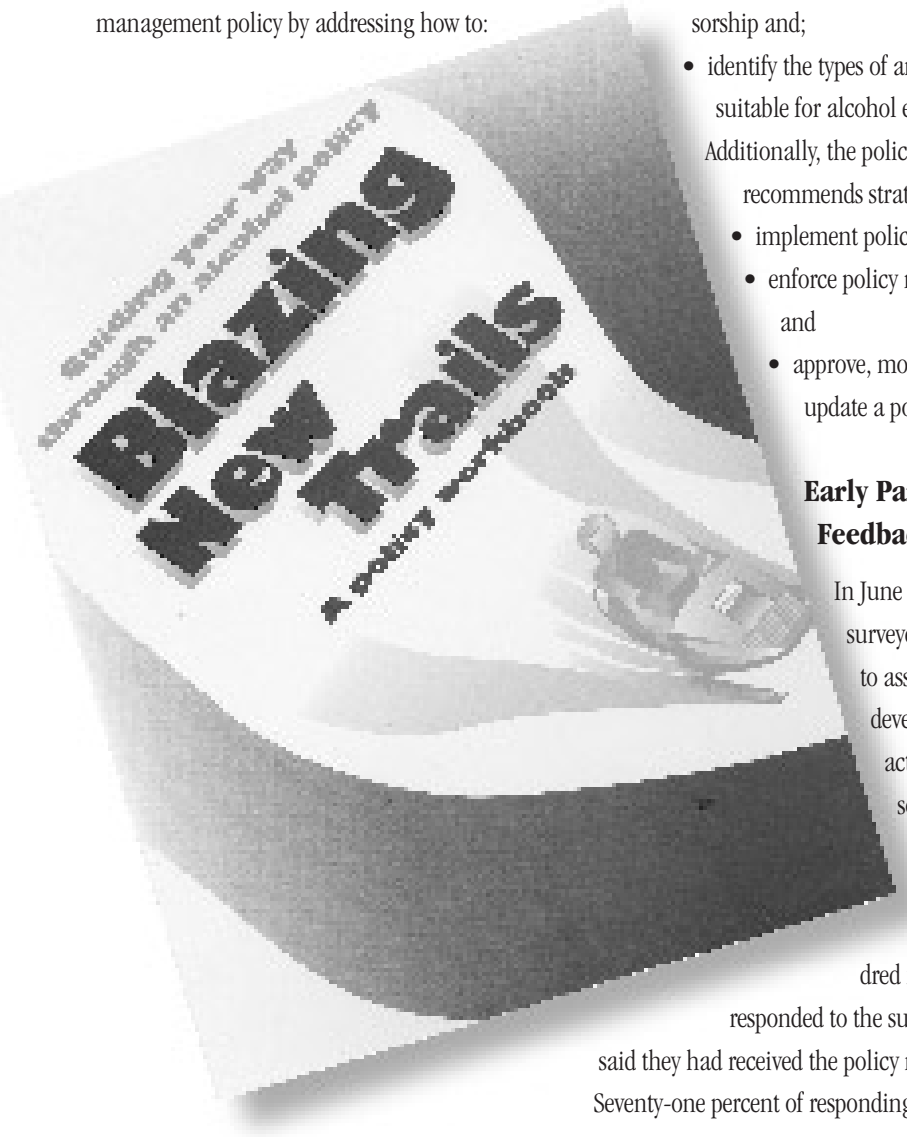
. . . how can we promote snowmobile safety on one hand and then host events where we risk sending our members or others to whom we have provided alcohol to their death?

The partners produced a policy workbook titled *Blazing New Trails—Guiding your way through an alcohol policy* and in 1998 disseminated it to OFSC clubs to stimulate policy action and test the utility of the workbook. This self-directed policy workbook includes an orientation video and outlines a step-by-step process for developing an alcohol-management policy by addressing how to:

- avoid intoxication;
- prevent impaired driving and illegal drinking;
- identify required event workers, their job duties and training requirements for alcohol events;
- assess insurance requirements;
- govern alcohol advertising and sponsorship and;
- identify the types of and locations suitable for alcohol events.

Additionally, the policy workbook recommends strategies to:

- implement policy regulations;
- enforce policy regulations and
- approve, monitor, and update a policy.



Early Participant Feedback

In June 1999, CAMH surveyed OFSC clubs to assess policy development activity and solicit feedback on the workbook. One hundred five clubs responded to the survey and 89 said they had received the policy materials. Seventy-one percent of responding clubs acknowledged giving the policy workbook a thorough review and 74 percent said they watched the video.

Twenty-five clubs reported that they had developed and adopted a policy, and were in the process of implementation. Seventeen clubs noted that their policies were only partially complete and 43 said they were intending to start the policy development process by December 1999, while only 20 clubs reported no intention of developing an alcohol policy. Overall, 80 percent of survey respondents noted some level of policy action.

Sixteen of the clubs with an adopted policy and the 15 clubs developing a policy that acknowledged using the policy workbook, collectively rated the *Blazing New Trails* policy workbook as being very useful. These clubs also said that policy development was important to them for the following reasons: to generally reduce alcohol-related problems; to improve the image of the sport; to reduce accidents; to address concerns about being sued; and to comply with policy directives by the OFSC. Some clubs commented on the policy resources by saying:

- well done
- protects the club
- in time should reduce trail damage
- it is the responsible thing to do

The 25 clubs that adopted policies said that they planned to inform their club's members about the policy at a membership meeting, by posting the policy in a visible location, having

policy discussions, and inserting a copy of the policy with the distribution of executive meeting minutes. The 17 clubs that reported that their policy was partially completed indicated an intention to complete one or all of the recommended developmental policy steps such as: establishing a policy development committee (7); meeting to discuss issues (11) and/or starting to write the policy (14).

Since policy adoption, 15 clubs reported that they have already noticed a reduction in problems after their policy went into effect. From a survey list of ten problems, club representatives indicated significant reductions in "drinking and riding snowmobiles" and "having members bring their own alcohol to club events." Clubs not noticing a difference reported that it was still too early in the process to observe a policy impact.

The dangers that alcohol use poses in snowmobiling coupled with the overall positive response by clubs to the policy workbook led the OFSC Board of Governors to pass a resolution in November 1999 requiring all clubs to develop an alcohol policy as a condition of OFSC membership. As of September 2000, more than 250 clubs have developed and submitted an alcohol policy to the OFSC.

CAMH research staff is assessing the quality of these policies in terms of their adherence to the policy template in the workbook. Any policy not meeting an acceptable standard will be returned to the respective club by the OFSC with improvement suggestions for resubmission. This standard is being maintained to protect club members and the OFSC from contributing to an alcohol-related crash that could lead to criminal charges and/or civil litigation.

CAMH is planing another survey of OFSC clubs to track continued policy development, assess policy quality, and measure the perceived impact on the minimization of problems. While future survey results, like those from the one already conducted, are not derived from a more rigorous research methodology, their importance to signaling change should not be underestimated. Since perceptions involve values, changing group values may be the first indicator of the adoption of a new behavior, as noted in the following quote by the past president of the OFSC, Bert Grant (1998):

"An alcohol policy makes sense. Just ask yourself, how can we promote snowmobile safety on one hand and then host events where we risk sending our members or others to whom we have provided alcohol to their death?"

Reggie (Regina) Caverson is a senior program consultant at CAMH. Ron Douglas is the program leader for the Community-based Prevention Program Area within the Communications, Education and Community Health Department at CAMH. Cindy Smythe is a research associate with the Prevention, Evaluation and Social Policy Research Department at CAMH. George Leakey is the driver training chair for the Ontario Federation of Snowmobile Clubs and co-chair of the Ontario Snowmobile Safety Committee.

Editor's note: This project was initiated with the former Addiction Research Foundation. In 1998, the ARF was integrated with other addiction and mental health services to create the Centre for Addiction and Mental Health, Canada's largest addiction and mental health organization. Readers interested in being notified of the release of *Blazing New Trails* can contact Caverson at Tel: 705/675-1195, Fax 705/675-9121, or E-mail:rcaverso@vianet.on.ca. Readers may also check CAMH product listings, by clicking on "Resources" at the CAMH Website at: www.camh.net.

COMMENTARY

WHY NOT 'DARE' TO TRY HARM REDUCTION IN PREVENTION?

For this issue, Prevention File *invited contributing editor Rodney Skager, PhD, to comment on how concepts of harm reduction might be applicable to prevention.*

THE HIPPOCRATIC OATH CAUTIONS DOCTORS against harming the patient. Still, many treatments in use today are "iatrogenic" in that they have negative side effects, chemotherapy for malignancy being a familiar example. Likewise, many medical conditions are chronic, but damage control can prolong the patient's life and reduce suffering.

Unfortunately, a similar perception of reality does not prevail for America's war on drugs. On this playing field, even whispering the words "harm reduction" is likely to result in a trip to the penalty box. One would not propose harm reduction strategies in a grant proposal to the National Institute on Drug Abuse or in the presence of General Barry McCaffrey (National Drug Control Policy Director, 1996 - 2000).

People comfortable with current policy have their reasons. Proponents of harm reduction usually believe that use of alcohol, tobacco, and illicit drugs will persist no matter how much is spent on interdiction, law enforcement, and anti-use messages. By drawing this conclusion they negate "zero tolerance" and the political fantasy of a drug-free America.

Worse, advocates of harm reduction address harms associated with drug policy, not just drugs. They point to the disastrous consequences of squandered billions, overflowing prisons, and abrogation of rights many Americans believe to be guaranteed in the Constitution. But what about prevention education? Are there harms associated with this ostensibly benign activity? Paradoxically, there are.

Three flaws in most current prevention programs cause significant harm to many children and youths. These are: (a) choosing indoctrination rather than education, (b) using inappropriate educational processes, and (c) applying deterrent punishment to kids who break the rules.

To indoctrinate means to imbue or implant a partisan or sectarian point of view. This is what many people had in mind when they suggested early prevention could "inoculate" children against trying drugs later on. In practice, indoctrination gives only one side of an issue, relies on half-truths or downright falsehoods, and demonizes people who see things differently.

The result of indoctrination against drugs (instead of education about drugs) is to make many adolescents more vulnerable. When they enter secondary school and discover that friends have tried marijuana and that school icons—student leaders, athletes, and even honor students—also use, early-prevention messages are deleted to the recycle bin.

People who choose to educate are often accused of "giving the wrong message." Here paradox becomes irony. Indoctrination with the "right" message turns out to have the wrong effect! Here is what one female student has to say: "Once we were in high school all that (DARE program) was just a bunch of gibberish.

Proponents of harm reduction usually believe that use of alcohol, tobacco, and illicit drugs will persist no matter how much is spent on interdiction, law enforcement, and anti-use messages.

I decided to stay drug-free because of my religious beliefs. It had nothing to do with the DARE program."

An urban Mexican American student describes how she initiated marijuana use early in high school: "The first time I ever smoked was with the student body president, we were just kicking it with these guys one time and they lighted it up. I was kinda surprised, I mean she was the student body president, AP (advanced placement) student, and she was smoking a joint. She offered it to me and I said 'yes.' I mean look at all of us, we're (university) students in high school, you know, we were referred to as the smart kids and we all tried weed."

What does harm reduction education have to offer? University of Washington researcher Alan Marlatt, PhD, suggests that, "harm reduction is about what works (pragmatism) and what helps (compassion)." Pragmatism acknowledges that many people will try drugs but will not progress to addiction or other personal catastrophe.

Most teens know this anyway, but admitting it establishes credibility. A male Mexican American student clearly recognizes this: "The problem isn't as big, because not everybody that smokes pot is a drug addict. So many teenagers try pot only a couple of times during their adolescence and then it's forgotten. It's like high school ends and so does the pot smoking, or people smoke it once in awhile, but it doesn't mess up their lives."

Education can embrace reality by dealing with real harms associated with use of alcohol and other drugs from the perspectives of the substance itself, the social context of use, and the psychological state of the user.

It can encourage responsibility for self and

Harm reduction advises abstinence, but recognizes that many young people will experiment.

others by informing learners on the signs of dependency and addiction, how enabling works, and how and when to offer help. But changing the content is not enough. For adolescents, who already know a lot about drugs, content is less important than process. Indoctrination is necessarily didactic and authority based. Adolescents resent this approach, especially when it is applied to personal life choices and ignores their experience. Prevention education with teens must be interactive. This means that learners participate in setting the agenda, feel free to share experience, and feel that what they say is heard and respected.

Kids are fully aware of the dark side of prevention, one that we professionals do not like to acknowledge. This is that schools (and society) use punishment to deter others rather than to reform the offender.

A senior woman student comments on the results of this policy: "You are continuing the problem by (expelling kids). A kid who comes to school high is obviously in need of some attention and guidance, and by kicking him or her out of school, you may eliminate the only stability or direction that he or she has in life."

A senior male student agrees: "Expulsion just encourages the negative behavior, and it leaves no alternative avenue open to the kid."

Deterrent punishment is not only damaging to those who are punished, it is also ineffective, as current rates of use would predict. A graduating Mexican-American female student puts it bluntly: "The rest of the students truly don't give a _____ if a student gets suspended for coming to school high, because they think they won't get caught, and they're right, most students don't get caught."

The compassion that Marlatt associates with harm reduction cannot prosper in a punitive institutional environment. It is hardly surprising that most California 11th-grade students think it unlikely that a fellow student would find help for a problem with alcohol or drugs at their school.

Concerned students and their teachers become enablers. They know, but they do not tell. A friend with an outstanding track record in building effective school and community programs observes, "Most teachers are caring and compassionate people. They are born enablers."

Harm reduction advises abstinence, but recognizes that many young people will experiment. Unlike the general no-use message of zero tolerance, harm reduction focuses on concrete problems associated with substance use. We need to challenge critics to be more specific about what they want to prevent. Drinking-and-driving programs based on harm reduction principles can be useful as illustrations. Finally, you can start by simply talking *with*, instead of *to*, kids. Ask them about their concerns and experiences relating to drugs and go from there. And then look for that "teachable" moment when their concerns mesh with what you have to contribute.

These Maps Show A Different View of a City

SOME MAPS ILLUSTRATE THE TYPOPOGRAPHY OF AN AREA, while others display streets and highways or population density. But the Geographic Information System maps that some California city officials and community groups are looking at pinpoint police encounters involving alcohol and other drugs.

These local officials and groups are using mapping information to identify the places and situations throughout the community in which alcohol and other drug-related problems concentrate to create problem environments. It's a new approach that highlights the effect of the environment on these problems and the responsibility of alcohol outlet owners who contribute to that environment. The maps are also used to reduce or prevent the problems from occurring.

The Alcohol/drug Sensitive Information Planning System GIS mapping system, or ASIPS/GIS, has been in use for the last four years to help cities like Berkeley, Vallejo, and Ventura target areas with high rates of alcohol and other drug-related incidents. ASIPS was created at CLEW Associates, a small planning firm, and the Community Prevention Planning Program at the Institute for the Study of Social Change, University of California (Berkeley). ASIPS originators Friedner Wittman, PhD, and Joe R Harding, PhD, have collaborated on ASIPS/GIS programs for the past ten years. Funding has come from federal, state, county, and foundation resources.

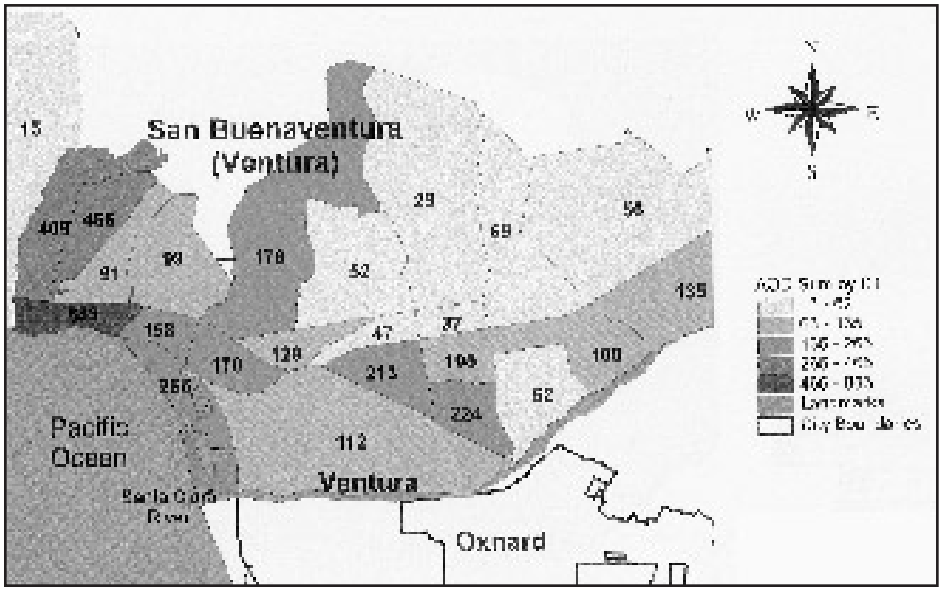
"We have developed a prototype with great potential," Wittman said. "ASIPS programs are tailored to meet the needs of each community.

Ventura ASIPS/GIS
Thompson Corridor Alcohol and Other Drug Events Summed by Address

GIS Maps can compile information and display it in a

Each time we do an ASIPS project we add new information and capabilities to the basic program, so it becomes easier to meet the next community's special needs. Our goal is to make ASIPS a user-friendly information utility that the community's local agencies and organizations can operate after we have set it up and trained them through a start-up period."

Instead of sending new people out into the community to gather the information needed to create a GIS map of a city, ASIPS taps the knowledge and expertise of the police and other public agencies, as well as the experiences of groups of citizens already involved in the everyday activities of the community. Police departments participating in ASIPS add a three-character indicator to their existing dispatch information and incident-reporting systems to show the presence or absence of alcohol and/or drugs in each call-for-service record or incident report. The special indicator also identifies the types of settings in which the incident occurs, such as residence, street, or alcohol outlet.



Ventura ASIPS/GIS
Alcohol and Other Drug Related Events
Summed by Census Tract

"Thus there is an automatic record of alcohol/drug involvement every time (the officer) sees it, deals with it, and makes a report on it," Wittman said. The special indicator is designed to become a permanent part of the recording system, so information on alcohol/drug involvement can be collected continuously. This makes ASIPS data useful for all aspects of problem solving, including monitoring to evaluate the results.

The next step involves the methodical and scientific compilation of ASIPS data for the community to use for prevention planning. At first, Wittman's team takes care of this part of the process, but once the ASIPS program has been tailored to meet the community's needs and local information specialists have been trained, subsequent work with ASIPS information can be done by local agencies and organizations. ASIPS documentation and reporting can be incorporated into the routine operations of police departments and other community agencies.

The aim is to reach the point where the community can do the assessment on its own, and in a sense, take care of its own problems. Cities that want to continue to use the program on their own, like Santa Barbara, Vallejo, and Berkeley, are eligible for a no-fee license to use the program in their jurisdiction with three stipulations that: restrict the use of the community's ASIPS program only to that jurisdiction, permit no unapproved modifications to the program, and require the sharing of data with CLEW Associates and/or the ISSC.

"It is especially important that they be willing to share their data," Wittman said. The data are used by the ASIPS group for their research and by other cities considering the program.

The mapping system "revolutionized" everything, according to Richard Scribner, MD, of the School of Medicine at Louisiana State University Medical Center. Scribner became interested in the GIS mapping during his internship in

way never seen before in the alcohol prevention field.

Los Angeles, where "half the patients were there for alcohol-related problems," according to Scribner. He also noticed that there was an alcohol outlet on every corner.

The system had traditionally been used for a city's land use purposes, such as assessing property values. GIS shows the impact of environments on specific problems because of the close-range focus of the maps. Studies done on city, county, or state levels are often too generic and broad-scoped. With the GIS, specific addresses and selected study areas are pinpointed. So, if the data show an inordinate amount of alcohol or other drug-related disturbances at a certain alcohol outlet or residence or neighborhood, outlet owners or homeowners or officials can be held accountable for what happens on their premises.

"I often use the example of the dirty windshield," Wittman said. "If your windshield is not clear, you can't see what's in front of you." The GIS maps provide a clear view of what alcohol and other drug-related events are happening and, more specifically, where they are happening. They clearly point the finger at irresponsible and delinquent alcohol outlets and other hot spots.

But ASIPS, with its focus on environments, does not discount the responsibility that individuals have for their actions

"Obviously the individuals have an effect," Scribner said. But both he and Wittman believe the local environment is a major contributor to a community's alcohol and other drug problems. Scribner used the example of the broken window test, where some researchers put a car with a broken window in a neighborhood and timed how long it took to get stripped. An identical car with windows intact was left alone for a much longer time. With the first car, the message was that nobody cared. And this, Scribner explained, is the message that the people get in the areas where there are liquor stores on every corner, where trash and graffiti reign.

In one of his papers, Scribner wrote, "Using small area analysis techniques enabled by GIS mapping technology, the group-level effect associated with alcohol outlet density at the neighborhood level can be partitioned into its group- and individual-level components."

GIS maps can compile information and display it in a way never seen before in the alcohol prevention field. The fact that maps can provide information on community hot spots helps people focus their efforts to solve specific alcohol and other drug-related problems in specific neighborhoods.

But once a community has these informative maps, how does it make use of that information? For Michael Sparks, project director/neighborhood specialist of Vallejo Fighting Back, the maps did at least two things. They helped shape public policy and helped in the selection of neighborhoods for revitalization projects (see *Prevention File*, Vol.15, No.4, Fall 2000).

"I would absolutely recommend the ASIPS program," he said. "I have recommended it to anybody who asked, and I just send them on to Fried."

"Community groups love these maps," Wittman said. "And city councils love them, too." Not only are they an impressive prop in any presentation, but they provide the high-quality information needed to withstand the scrutiny in court proceedings and agency hearings that mandate changes in problem environments. Often, when a community group targets a delinquent or irresponsible alcohol outlet because the data show an inordinate number of police incidents at that address, legal action may follow.

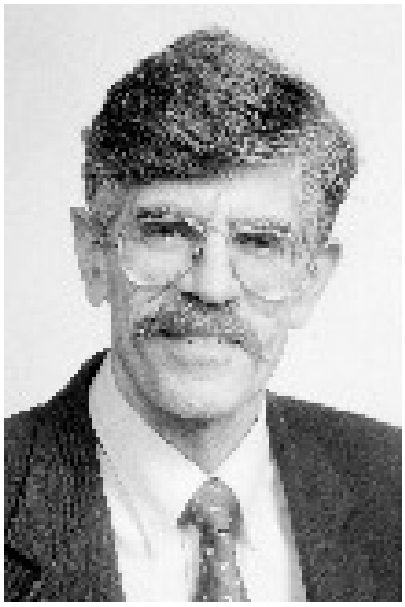
"If the situation is pushed, those involved must have legal documentation to take legal action," Wittman said.

According to Wittman, people often expect that the police, familiar with neighborhoods as they are, will have a good idea of the local hot spots, and perhaps could use the help of ASIPS to support their suspicions. But the police work on an anecdotal basis and often don't sum things up amongst themselves regularly or in a structured manner.

"The police are sometimes surprised by what ASIPS shows them," Wittman said. While each officer does see a lot on his or her beat, when incident reports are compiled, they may show a very different picture when it comes to community hot spots.

"ASIPS information provides a high level of accuracy and ability to describe the problem," Wittman said.

For additional information on the ASIPS program developed by Fried Wittman, call 510/540-4717 or e-mail: clew_associates@msn.com
For information on the GIS/mapping technology research of Richard Scribner, call 504/568-6951 or e-mail: rscrib@lsumc.edu



Q&A with Alan Blum

Alan Blum, MD, is a family physician and professor of family medicine who in 1977 founded Doctors Ought to Care (DOC) in an effort to persuade more medical professionals to speak out against the marketing tactics of the tobacco and alcohol industries. DOC became a pioneer in paid counter-advertising, a technique for using the mass media to undermine the impact of advertisements that encourage smoking and drinking. Now the director of the Center for the Study of Tobacco and Society at the University of Alabama, Blum sees disturbing trends in the movement he helped start and airs those feelings in this interview with Prevention File.

You and Eric Solberg, the executive director of DOC, were roundly criticized criticized in 1994 in Paris at the Ninth World Conference on Tobacco OR Health when you delivered a paper talking about revisionism, magical thinking, and 'hokey-pokey objectives' in the antismoking movement. Why was that?

A: We made ourselves the sacrificial lambs by questioning the tenets, principles, and consistency of the movement. No one is doing this. No one has sat down and asked the right questions. What do we want? What are we doing right? What are we doing wrong? It's always, 'I have a grant and therefore I exist.' The point we made was that there's a lack of prioritization in the movement, no division of responsibility, excessive duplication of efforts, and above all, a lack of accountability. The response to our paper from individuals in Europe, Asia, and developing nations was positive, but not so from some of our well-funded colleagues in the United States and Canada. We tried to ask whether the emperor was wearing any clothes, and few in the establishment wanted to hear that.

But haven't there been some victories along the way? Successful lawsuits against the cigarette companies, higher taxes on tobacco, bans on smoking in public places?

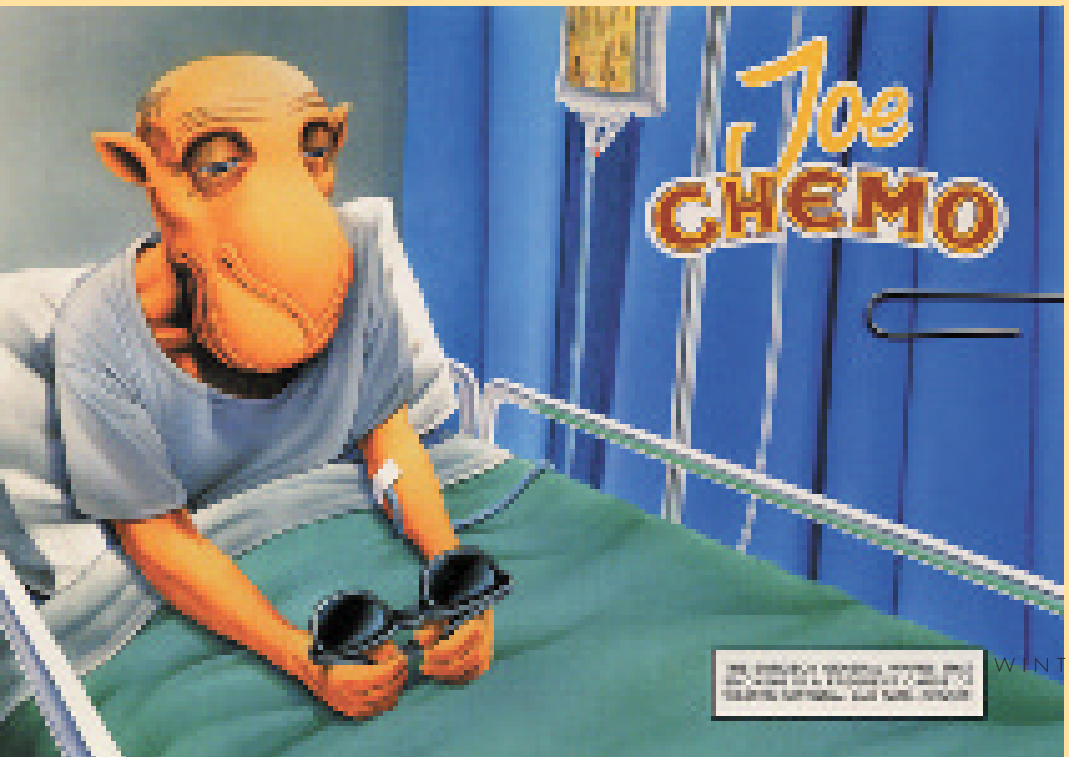
A. I give all the credit in the world to the people who were trying to reduce smoking in public places, like the people at ASH and GASP. The United States has paved the way around the world in removing smoking from public places. Where we get confused is when we turn to the issue of advertising of cigarettes and how we deal with the tobacco industry. When I hear the term 'tobacco control' it worries me. As if we could win this war if we just pass tougher laws and get the government involved in fighting smoking. California is the state touted as having the very best 'tobacco control.' Well, we're not controlling some leaf. It's not like mosquito control. If you take California as a leading example of institutionalizing antismoking activity, I think you'll see see some successes but also quite a lot of failed efforts and wasted funding.

Why does DOC concentrate so heavily on the media?

A. I've always believed that laughing the pushers out of town was a much better way to go than trying to ban them. When we try to be a prohibitionist society it just doesn't work. It garners sympathy for the people we're trying to

I've always believed that laughing the pushers out of town was a much better way to go than trying to ban them.

prohibit. From day one in 1977, our goal was to shift the focus away from nicotine and smokers, away from addiction and lung cancer, and put the focus on the tobacco industry. I came up with five objectives that we've never changed. First, to educate the public in refreshing ways about the major preventable causes of poor health and high medical costs. Two, to tap the highest level of commitment of every health professional in this aim. Three, to tap the highest level of creativity of every teenager; that is, let them design posters and counter—ads that are not about smoking but about deconstructing and ridiculing Marlboro and all the other brands. Four, to use humor and satire, and not fear-mongering and moral outrage in our work. Finally, to purchase advertising time and space in the mass media. We've never added or subtracted from any of those five objectives for DOC.



Is more money being spent these days on counter-advertising?

A. Most of what we see is not counter-advertising but antismoking messages. My definition of counter-advertising is those ads that undermine the advertisements of the industry's products, that go counter to the very images and brand names and corporate messages that the tobacco industry wants to get across. They parody or satirize the brand or the ad or the company. For example, years ago when Dakota cigarettes were being launched by RJ Reynolds to try to lure young women away from Marlboro, we came up with the slogan 'Dakota, DaCough, DaCancer, DaCoffin.' The daily papers in Houston wouldn't run our ad, but an alternative paper did, and it lost all its RJ Reynolds advertising as a result.

All to many of the newly arrived anti-smoking campaigners, such as the ad agencies for the American Legacy Foundation, like to think they're doing counter-advertising. In fact, they've completely skipped over the product to beat up on 'Big Tobacco.' This ignores the dynamic nature of the tobacco industry, which constantly changes its identity and imagery through mergers, acquisitions of food companies, promotion of charitable endeavors, cre-

ation of sports and arts sponsorships, and, most recently, its own youth antismoking campaigns.

The name of your organization suggests that you've been trying since 1977 to get doctors to care more about smoking and drinking issues. Do they care more today than they did then?

A. The medical profession is more attuned to tobacco issues than alcohol issues, but sadly the pharmaceutical industry has medicalized smoking into one of smoking cessation. You might argue that just as drinking has been co-opted by the alcohol industry into issues of drunk driving and underage drinking, so the tobacco issue has been co-opted by the pharmaceutical industry with its cessation gimmicks. DOC has fewer contributors from doctors compared with what it used to have. I feel what happened on the smoking issue is that around 1990 the Joint Commission on Accreditation of Hospitals recommended that hospitals restrict smoking. Most physicians work in hospitals, and when they see no smoking going around them, they think everybody's stopped smoking. More than 20 years ago, I warned that complacency was the foremost obstacle to confronting the tobacco issue. I believe it still is.

The cigarette companies seem to have taken some serious hits in court decisions recently. Is this encouraging to you?

A. If I were an embezzler and had been socking away a few billion a year knowing that at any moment I might get caught, and I was putting those billions into a daily compound-interest account, and suddenly I got caught, well, I'd have to hand back some of those billions, but I'd have plenty more where they came from. The hits the cigarette companies have taken have dropped their popularity among good, decent, liberal-minded people, but I think this has been almost evenly matched by their resourcefulness in changing their identity like a wolf in sheep's clothing, saying, 'hey, we're not just a cigarette company, we're a patron of the arts, we give poor people food, and so forth.'

So what do you do about that?

A. When Philip Morris runs ads saying what a wonderful company they are, we should be up there saying: 'A wonderful company? Let us show you want Philip Morris really is.' Someone suggested doing a split-screen counter-ad showing Philip Morris sponsoring the arts on one side and a patient with emphysema on the other side. We have an incredible opportunity. We've wounded the industry. Now we should home in and cripple it. And yet we aren't doing that. I'm the resident critic on this issue, but at the same time I'm an optimist. What's been discouraging is to see the lack of understanding of the history of tobacco and the way it's been promoted and sold. There's a world conference on tobacco every three years. At the last one there were 4,500 people present; 76 percent were there for the first time, and 90 percent had their presence paid for by a grant. That's not an indigenous movement, that's a bureaucratization, and that's dangerous. It says, 'Wow, we've got all this money, now let's hire all these new people.' But there's not enough experience in this new corpus of people to make much progress. A student graduating from a school of public health today can readily find a full-time salaried position working on tobacco policies for a health department or voluntary organization, with no experience beyond having heard a lecture or two on smoking in a course in epidemiology.

In the 1980s C. Everett Koop, the Surgeon General, set the goal of 'a smoke-free generation by the year 2000.' The National Cancer Institute projected a goal of reducing smoking by 50 percent by the year 2000. We had these lofty rhetorical objectives and we failed abysmally. Yet we don't see any analyses of why this happened. There are no meetings going on to plan our campaigns. We have a world meeting every three years while the tobacco companies meet every day of the week to plan how they're going to make money out of smoking. I joke with my colleagues at the American Cancer Society about their "Great American Smoke-Out" being just one day a year. Why not have 364 smoke-outs, I've asked, and give the tobacco industry one day a year to have a 'smoke-in'? ☐

Continued from inside front cover

"When the husband is a heavy drinker but the wife is not, aggression is more likely in the second and third years of marriage," said Brian M. Quigley, PhD, of the University at Buffalo, State University of New York. He and his co-author Kenneth E. Leonard, PhD, based their findings on interviews with more than 400 couples. The researchers found that 45 percent of couples reported at least one incident of violence during the second or third years of their marriage. And violence during the first year was strongly related to violence during the next two years.

Leonard and Quigley report that, as expected, heavy drinking among husbands during the first year predicted later violence—except in couples where the wife was also a heavy drinker.

The impact of a husband's alcohol use depended on the wife's drinking style. The highest levels of violence were associated with couples in which the husband was a heavy drinker and the wife was not.

It's the Government's Job

More than 90 percent of Americans believe it is the government's responsibility to regulate tobacco, according to *Smoking in America,* a national survey conducted by the Mississippi State University.

The survey also found that more than 90 percent of those surveyed believe that smoking harms children, although more than 20 percent allow smoking in the presence of youngsters. And while more than 96 percent disagree with the claim that nicotine is not addictive, over 20 percent believe that smoking is not dangerous or only slightly dangerous.

"While there clearly has been a dramatic decline in the number of smokers since the U.S. Surgeon General in 1964 first announced the health risk of tobacco, the message has not consistently taken hold across the fabric of society," said researcher Robert McMillen.

The survey also found that 70 percent of Americans prohibit smoking in their homes. While 90 percent of respondents said students should not be allowed to smoke at school, 43 percent said it was okay for teachers and staff members to smoke there.

"We found that children are getting a very mixed message from adults," McMillen said.

Roadblock Out for Drug Searches

Random roadblocks intended for drug searches are an unreasonable invasion of privacy under the Constitution, according to a recent ruling from the U.S. Supreme Court. Law enforcement in and of itself is not a good enough reason to stop innocent motorists.

"Because the checkpoint program's primary purpose is indistinguishable from the general interest in crime control, the checkpoints contravened the Fourth Amendment," which protects against unreasonable searches and seizures, Justice Sandra Day O'Connor wrote.

O'Connor stressed that the high court ruling does not affect other police roadblocks such as border checks and drunk-driving checkpoints, which have already been found constitutional. But the reasoning behind those kinds of roadblocks—chiefly that the benefit to the public outweighs the inconvenience—cannot be applied broadly.

"If this case were to rest on such a high level of generality, there would be little check on the authorities' ability to construct roadblocks for almost any conceivable law enforcement purpose," the ruling said.

Ten Years Ago in *Prevention File* (Vol. 6, No. 1, Winter 1991)

RESCUING PARKS FROM ALCOHOL, DRUG DEALERS, GANGS

"In scores of city parks across Los Angeles—mostly cramped sites in poor neighborhoods—the fear is high. So pervasive are gangs, drug dealers, and drunks, so limited are the programs and facilities, that the sites are known to parents and even some recreation leaders as 'dead parks.'"

Thus wrote a *Los Angeles Times* reporter in 1987, describing a problem familiar to residents of many American cities. What's wrong? Neighborhood parks are supposed to have a positive role in a community's social and cultural life. They can provide a leafy refuge from the aggravations of city life, and an opportunity for wholesome recreation for young people.

Parks that are dead or dying appear to be the victims of a combination of circumstances.

Part of the problem is a squeeze on public funds for park programs, such as the one that befell local governments in California with the passage of the tax-limiting Proposition 13 in 1978.

Part of the problem is the rise of street traffic in illegal drugs, which has made city parks a favorite hangout for drug dealers and drug users.

Part of the problems is public drunkenness and inadequate policies for control and sale of alcoholic beverages.

Part of the problem is homelessness—the lack of shelters and rehabilitation programs for the homeless, or the unwillingness of homeless people to leave the freedom of the parks for the constraints of life in shelters and rehab programs.

Whatever the cause of the disease, it needn't be fatal.

Consider another article from the *Los Angeles Times Magazine* (May 28, 1989) two years after the newspaper's description of 'dead parks' in that city. The 1989 report describes how Aliso-Pico Park was rescued from gangs, graffiti, and filth to become one of the most successful parks in the city. "Every week more than 850 children participate in the center's 19 sports, cultural, and academic programs. And although crime has risen in the area, Los Angeles police say it rarely enters the park's boundaries."

According to the *Times*, Aliso-Pico Park saw its rebirth through a combination of public and private effort, mobilized by the park's recreation director Joyce Nishimuro. Businesses in the neighborhood formed a nonprofit corporation to supplement city funds for the Aliso-Pico recreation program. Nishimuro says she convinced the businesspeople that if they take money out of the community, they need to put some of it back.

Nishimuro and others who have struggled through similar efforts believe community involvement is the key. Saving parks can be a goal of the community-oriented or problem-oriented policing, which is catching hold in some cities. These approaches recognize that incident-oriented policing, i.e., responding to crimes or disturbances, and arresting or dispersing those responsible—does not go far enough.

Editor's note: Rallying communities to take greater control of their environments to reduce crime and disorder has become an increasingly important part of local prevention efforts. These ideas are elaborated in the book Fixing Broken Windows, *by George L. Kelling and Catherine M. Coles (Martin Kessler Books, 1996) and discussed in* Prevention File *(Vol. 12, No.4, Fall 1997).*